REC 001783
AU Shiffman,SM; Jarvik,ME
TTL Smoking Withdrawal Symptoms in Two Weeks of Abstinence
CT Psychopharmacology 50(-): 35
DT 1976
SUM Desire to smoke was found to vary significantly as a function of days. Craving showed a significant linear decrease over the 12 days studied. : The craving of the totally abstinent SS drops more sharply and consistently than that of the partially abstinent SS, which drops only slightly.
SUBJ A1G, TERMS, CRAVING
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 001784
AU Shiffman,SM; Jarvik,ME
TTL Smoking Withdrawal Symptoms in Two Weeks of Abstinence
CT Psychopharmacology 50(-): 35
DT 1976
SUM Although much has been written on the cigarette abstinence syndrome, the existence, nature, and course of the syndrome has not yet been adequately documented. The Surgeon General's Report (1964, p. 352) describes a variety of symptoms of increased or decreased excitability, but concludes that "no characteristic abstinence syndrome occurs" following cessation of smoking. Russell (1971) describes similar symptoms, but reaches the opposite conclusion that an abstinence syndrome can be said to occur.; Desire to smoke was found to vary significantly as a function of days. Craving showed a significant linear decrease over the 12 days studied. : The craving of the totally abstinent SS drops more sharply and consistently than that of the partially abstinent SS, which drops only slightly.; Overall, SS reported mild psychological discomforts such as anxiety and restlessness, with light and heavy smokers reporting similar levels of discomfort. Reports of psychological symptoms did, however, show changes as a function of days in abstinence. There is a significant linear decrease in reports of psychological discomforts over time. Also, the curve of psychological symptoms plotted by days shows significant quadratic curvature, falling from day 2 to day 5, and then slowly rising again.; Overall, SS reported very few and mild physical symptoms, and light and heavy smokers did not differ in this respect. Reports of physical symptoms did, however, show significant change across days. The trend for physical symptoms reported as a function of days shows significant quadratic curvature, "dipping" slightly in the middle of the 12-day abstinence period. Although totally and partially abstinent SS do not differ in their mean physical symptoms score, the data suggest that the above-mentioned quadratic curvature is affected by the abstinence status of the SS. It appears that totally abstinent SS experience a greater drop in physical symptoms in the middle of the abstinence period than do partially abstinent SS.
SUBJ I1A, WITHDRAWAL, NICOTINE
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 000257
AU Shiffman,SM
TTL The Tobacco Withdrawal Syndrome
CT In: Cigarette Smoking as a Dependence Process. N. A. Krasnegor (ed.). N.I.D.A. Research Monograph Series 23. National Institute on Drug Abuse, Rockville, Maryland, Chapter 11, pp. 158-185 [part of Jaffe expert report article #36]
DT January, 1979
SUM Characterizing tobacco use as a dependence process necessarily raises the issue of tobacco withdrawal, as the presence of an abstinence syndrome is crucial to the definition of drug dependence. Indeed, some of the initial reluctance to label tobacco as a dependence-producing substance rested on doubts concerning the existence of a tobacco withdrawal syndrome. . . . (p. 158)
SUBJ B1A, TOBACCO/NICOTINE, AS ADDICTION
CD MARCH 1, 1987 SHB

REC 000318
AU Shiffman,SM
TTL The Tobacco Withdrawal Syndrome
CT In: Cigarette Smoking as a Dependence Process. N. A. Krasnegor (ed.). N.I.D.A. Research Monograph Series 23. National Institute on Drug Abuse, Rockville, Maryland, Chapter 11, pp. 158-185 [part of Jaffe expert report article #36]
DT January, 1979
SUM While the time course of the abstinence syndrome following abrupt withdrawal from other dependence-producing substances has been systematically studied (Jaffe 1971), assessment of the course of the tobacco withdrawal syndrome is made difficult by the subtlety and variability of the symptoms (JSDHEW, 1964). (p. 165)
SUBJ C1E, TOBACCO COMPARISON, WITHDRAWAL
CD MARCH 1, 1987 SHB

REC 000335
AU Shiffman,SM
TTL The Tobacco Withdrawal Syndrome
CT In: Cigarette Smoking as a Dependence Process. N. A. Krasnegor (ed.). N.I.D.A. Research Monograph Series 23. National Institute on Drug Abuse, Rockville, Maryland, Chapter 11, pp. 158-185 [part of Jaffe expert report article #36]
DT January, 1979
SUM . . . Despite the usefulness of gradual withdrawal in other dependence disorders, and despite the congruence of this method with sound behavioral principles, there is considerable evidence suggesting that gradual withdrawal from tobacco is associated with treatment failure . . . (p. 171)
SUBJ C1G, TOBACCO COMPARISON, CESSATION
CD MARCH 1, 1987 SHB

REC 000446
AU Shiffman,SM
TTL The Tobacco Withdrawal Syndrome
CT In: Cigarette Smoking as a Dependence Process. N. A. Krasnegor (ed.). N.I.D.A. Research Monograph Series 23. National Institute on Drug Abuse, Rockville, Maryland, Chapter 11, pp. 158-185 [part of Jaffe expert report article #36]
DT January, 1979
SUM . . . The impression might be drawn that every smoker, upon withdrawal from tobacco, becomes irritable and anxious and is unable to think, work, sleep, drive, or carry on normal social discourse for want of a cigarette. Fortunately, this is not the case. The tobacco withdrawal syndrome is apparently quite variable in character, severity, and duration. An examination of various studies reveals large differences in the frequency with which particular symptoms are reported. . . . (p. 161); It is characteristic of withdrawal syndromes that their severity is dose dependent (Jaffe 1971). Therefore, it is expected that heavy smokers would report more severe withdrawal symptoms than light smokers. A comparison of subjects smoking a pack or more (x=26.6) per day with those smoking less than a pack (x-15.7) per day, however, revealed no overall differences in the severity of their symptoms. This replicates our previous finding that light and heavy smokers do not differ in craving when deprived for 48 hours (Gritz and Jarvik 1973). . . . (pp. 161-162); The onset of the syndrome appears to be rapid, with changes in mood (Schachter and Rand 1974) and performance (Myrsten et al. 1972) evident as early as two hours after withdrawal. However, these early effects are not easily distinguishable from the absence of nicotine effects or the effects of simple frustration. . . . (p. 165); . . . Thus, the duration of the tobacco withdrawal syndrome appears to be extremely variable, and no definite estimate is yet available. (p. 168); . . . Thus, abrupt and total withdrawal from tobacco is associated with a withdrawal syndrome that is no worse than that seen in partial abstinence, and which subsides more quickly. (p. 171)
SUBJ I1A, WITHDRAWAL, NICOTINE
CD MARCH 1, 1987 SHB

REC 003
AU Shiffman,SM; Gori,GB; Bock,FG; Jarvik,ME; PPerlick,D; Hoffmann,D; Battista,SP; Russell,MAH; Cain,WS; Rauschenberger,J
TTL A Safe Cigarette? Session 5: Behavioral and Economic Issues: Diminished Smoking, Withdrawal Symptoms, and Cessation: a Cautionary Note
CT Banbury Rep 0(3): 283-296
DT 1980
SUM
SUBJ
CD FEBRUARY 1, 1988 SHB

2124909975

REC 003201
AU Shiffman,SM; Gori,GB; Bock,FG; Jarvik,ME; Perlick,D; Hoffmann,D; Battista,SP; Russell,MAH; Cain,WS; Rauschenberger,J
TTL A Safe Cigarette? Session 5: Behavioral and Economic Issues: Diminished Smoking, Withdrawal Symptoms, and Cessation: a Cautionary Note
CT Banbury Rep 0(3): 283-296
DT 1980
SUM
SUBJ
CD FEBRUARY 1, 1988 SHB

REC 002491
AU Shiffman,S
TTL Relapse Following Smoking Cessation: A Situational Analysis
CT J Consult Clin Psychol 50(1): 71
DT 1982
SUM Table 1 shows the activities in which the ex-smokers were engaged just prior to the onset of the relapse crisis. It shows that a large proportion of the crises (nearly one third) occurred when the ex-smokers had been eating. A nearly equal number were engaged in positive social activity at the time of the crisis. (Negative social interactions such as arguments were classified as "other activity.") These two activities often went together, so that 12% of the same were engaged in socializing over food or drink. The "other" activities occupying one third of the subjects included activities such as driving and shopping.; The majority of relapse crises (56%) took place in the subjects' homes, with the remainder equally distributed between the workplace (21%) and other locations such as restaurants, bars, and friends' homes (23%). Most of the time (61%), other people such as family members or coworkers were present, especially when the crisis took place outside the ex-smoker's home. In about half of these cases (comprising 32% of the sample as a whole), one of the other people present was smoking. Given the presumed salience of smoking cues to the initiate ex-smoker, the presence of other smokers is likely to play an important role in precipitating relapse crises. This suggests that ex-smokers may endanger their maintenance efforts through continuing social contact with other smokers. Perhaps this accounts in part for the findings of Eisinger (1971) and of Tongas et al. (note 1, note 2) that ex-smokers whose friends or spouses smoke are more likely to relapse.
SUBJ EID, MOTIVATIONS, NONPHARM
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

2024982976

REC 002492
AU Shiffman,S
TTL Relapse Following Smoking Cessation: A Situational Analysis
CT J Consult Clin Psychol 50(1): 71
DT 1982
SUM In sum, the data on withdrawal symptoms consistently suggest that they are often not responsible for the immediate precipitation of relapse. Perhaps only some relapses are motivated by relief from withdrawal, while others are motivated by anticipation of other reinforcing effects of smoking.
SUBJ I1A, WITHDRAWAL, NICOTINE
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 002493
AU Shiffman,S
TTL Relapse Following Smoking Cessation: A Situational Analysis
CT J Consult Clin Psychol 50(1): 71
DT 1982
SUM In sum, the data on withdrawal symptoms consistently suggest that they are often not responsible for the immediate precipitation of relapse. Perhaps only some relapses are motivated by relief from withdrawal, while others are motivated by anticipation of other reinforcing effects of smoking.; Table 1 shows the activities in which the ex-smokers were engaged just prior to the onset of the relapse crisis. It shows that a large proportion of the crises (nearly one third) occurred when the ex-smokers had been eating. A nearly equal number were engaged in positive social activity at the time of the crisis. (Negative social interactions such as arguments were classified as "other activity.") These two activities often went together, so that 12% of the same were engaged in socializing over food or drink. The "other" activities occupying one third of the subjects included activities such as driving and shopping.; The majority of relapse crises (56%) took place in the subjects' homes, with the remainder equally distributed between the workplace (21%) and other locations such as restaurants, bars, and friends' homes (23%). Most of the time (61%), other people such as family members or coworkers were present, especially when the crisis took place outside the ex-smoker's home. In about half of these cases (comprising 32% of the sample as a whole), one of the other people present was smoking. Given the presumed salience of smoking cues to the initiate ex-smoker, the presence of other smokers is likely to play an important role in precipitating relapse crises. This suggests that ex-smokers may endanger their maintenance efforts through continuing social contact with other smokers. Perhaps this accounts in part for the findings of Eisinger (1971) and of Tongas et al. (note 1, note 2) that ex-smokers whose friends or spouses smoke are more likely to relapse.
SUBJ K1DA, CESSATION, RELAPSE, NICOTINE
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

2024967977

REC 002826
AU Shiffman,S
TTL Relapse Following Smoking Cessation: a Situational Analysis
CT J Consult Clin Psychol 50 (1): 71-86
DT 1982
SUM Nearly half of the callers reported experiencing no symptoms at all. This information casts doubt on the widely held hypothesis that withdrawal symptoms are the primary culprits in relapse. Apparently, many relapsing exsmokers are not seeking relief from withdrawal symptoms. On the other hand, these data show that the majority of relapse crises were indeed associated with withdrawal symptoms. (p. 76); A second point of interest is that nearly half of the subjects reported experiencing no withdrawal symptoms at any time. This is a surprisingly low prevalence, especially in a sample of ex-smokers seeking help with maintenance. (p. 76); Finally, only 4.3% of the subjects reported experiencing their first bout of withdrawal symptoms, which suggests that such initial hurdles do no precipitate relapse. In sum, the data on withdrawal symptoms consistently suggest that they are often not responsible for the immediate precipitation of relapse. Perhaps only some relapses are motivated by relief from withdrawal, while others are motivated by anticipation of other reinforcing effects of smoking. (p. 76); Withdrawal symptoms, in contrast, play a lesser role as immediate antecedents of relapse than is ascribed to them in the literature. . . . In our data, the experience of symptoms seemed inversely related to relapse. (p. 84)
SUBJ I1A, WITHDRAWAL, NICOTINE
CD NOVEMBER 1, 1987 SHB

REC 002827
AU Shiffman,S
TTL Relapse Following Smoking Cessation: a Situational Analysis
CT J Consult Clin Psychol 50 (1): 71-86
DT 1982
SUM Nearly half of the callers reported experiencing no symptoms at all. This information casts doubt on the widely held hypothesis that withdrawal symptoms are the primary culprits in relapse. Apparently, many relapsing exsmokers are not seeking relief from withdrawal symptoms. On the other hand, these data show that the majority of relapse crises were indeed associated with withdrawal symptoms. (p. 76); Finally, only 4.3% of the subjects reported experiencing their first bout of withdrawal symptoms, which suggests that such initial hurdles do no precipitate relapse. In sum, the data on withdrawal symptoms consistently suggest that they are often not responsible for the immediate precipitation of relapse. Perhaps only some relapses are motivated by relief from withdrawal, while others are motivated by anticipation of other reinforcing effects of smoking. (p. 76); Withdrawal symptoms, in contrast, play a lesser role as immediate antecedents of relapse than is ascribed to them in the literature. . . . In our data, the experience of symptoms seemed inversely related to relapse. (p. 84); In a study of relapse process in ex-smokers, data on the antecedents of relapse crises (actual or near lapses in abstinence) were collected from 183 ex-smokers who called a relapse-counseling hotline. . . . Withdrawal symptoms played a lesser role than expected: Half of the episodes occurred in the absence of symptoms. (p. 71); The absence of withdrawal symptoms was significantly associated with smoking in relapse crises . . . . This effect held for symptoms as an aggregate but did not apply to any one of the types of symptoms recorded. . . . In view of the evidence relating withdrawal symptoms to relapse, . . . it seems doubtful that the symptoms have any prophylactic effect in relation to relapse. It is more likely that this implausible inverse relationship reflects a sampling bias. . . (p. 78)
SUBJ KIDA, CESSATION, RELAPSE, NICOTINE
CD NOVEMBER 1, 1987 SHB

REC 002978
AU Shiffman,S; Jarvik,ME
TTL Cigarette Smoking, Psychological Arousal, and Emotional Response: Nesbitt's Paradox Re-Examined
CT Addict Behav 9(1): 95-98
DT 1984
SUM While it has been demonstrated in the laboratory that stress increases smoking (Rose, Anada, & Jarvik, in press), the converse - that smoking reduces affect - has not been convincingly demonstrated. (p. 95)
SUBJ G1A, PSYCHOLOGICAL EFFECTS, NICOTINE
CD JANUARY 1, 1988 SHB

2024987979

REC 002974
AU Shiffman,S
TTL Cognitive Antecedents and Sequelae of Smoking Relapse Crises
CT J Appl Soc Psychol 14(3): 296-309
DT 1984
SUM In all cases, subjects with higher efficacy expectations show superior performance. Condiotte and Lichtenstein (1981) have also shown that exsmokers tend to relapse in situations for which their efficacy expectations are lowest. (p. 297); Whether they smoked or not, people who produced no coping response were significantly more likely to report feelings of failure. (p. 303); A detailed analysis showed that it was precisely those subjects who had experienced the greatest increase in self-efficacy who were most likely to relapse. This is probably related to a finding by Gottleib, Friedman, Cooney, Gordon, and Marlatt (1981) that exsmokers who are confident that they can smoke "just one" cigarette have greater rates of relapse. These studies suggest that while self-efficacy is generally helpful, it is possible to be overconfident. (pp. 306-307)
SUBJ K1F, CESSATION, SELF-EFFICACY
CD JANUARY 1, 1988 SHB

REC 002980
AU Shiffman,S
TTL Coping with Temptations to Smoke
CT J Consult Clin Psychol 52(2): 261-267
DT 1984
SUM Both behavioral and cognitive coping responses abstinence in the face of temptation to smoke. (p. 264); . . . the performance of coping responses helps maintain abstinence in the face of temptation. (p. 267)
SUBJ K1F, CESSATION, SELF-EFFICACY
CD JANUARY 1, 1988 SHB

REC 002979
AU Shiffman,S; Prange,M
TTL Self-Reported and Self-Monitored Smoking Patterns
CT Pharmacol Biochem Behav 20(6): 986
DT June, 1984
SUM . . . the results did not support the validity of commonly-used self-report scales of smoking motives and situations.
SUBJ V1A, RESEARCH CRITICISM, SELF-REPORT
CD JANUARY 1, 1988 SHB

REC 000531
AU Shiffman,S
TTL Coping with Temptations to Smoke
CT Coping and Substance Abuse, Chapter 9, S. Shiffman and T. A. Wills (eds.), pp. 223-242.
DT 1985
SUM These data on the details of the relapse process confirm the importance of coping processes in control of smoking and support the stress reduction model of smoking. The data show that attempts to cope with temptation were the single best predictor of outcome in a relapse crisis. . . . (p. 235); The data are generally consistent with a coping model of cigarette smoking and relapse and inconsistent with a purely biological -- addictive view of smoking relapse. Simple biological models of smoking relapse propose that the drug use itself sets up physiological processes that motivate further drug use. Although this model attributes relapse to withdrawal symptoms, the data show that such symptoms were often absent in smoking relapse situations. . . . (p. 236); Data from exsmokers undergoing relapse crises emphasize the importance of stress and coping in smoking relapse. The data are more consistent with an adaptational view of smoking -- that it is used to deal with stress -- than with a simple biological model of drug dependence. Moreover, the data highlight the importance of coping in resisting temptations to smoke: Coping was the strongest determinant of survival in a relapse crisis. . . . (pp. 239-240)
SUBJ KIDA, CESSATION, RELAPSE, NICOTINE
CD MARCH 1, 1987 SHB

REC 001820
AU Shiffman,S; Read,L; Maltese,J; Rapkin,D; Jarvik,ME
TTL Preventing Relapse in Ex-Smokers: A Self-Management Approach
CT Relapse Prevention, pp. 472-520
DT 1985
SUM Since smoking is often used to mask needs, smokers are often out of touch with important needs. This hampers selection of appropriate alternatives. Clients need help in labeling their needs and in finding other ways of satisfying them. In the section on coping skills, we discussed a number of substitutes that may be effective in reducing craving. Early in treatment, many substitutes may be used in lieu of having a cigarette. Many of these substitutes cannot be used for long periods of time without harmful side effects, however. Eating sweets or taking tranquilizers may be appropriate as stopgap measures, but create problems in long-term use. Such substitutes also perpetuate the cycle of deprivation, craving, and dependence. Clients need appropriate skills for satisfying the needs flagged by craving without smoking. A more satisfying, need-fulfilling lifestyle also makes craving for cigarettes less likely. The assumption here is that other behaviors can satisfy these needs at least as effectively as smoking and can therefore displace smoking as a valued activity.
SUBJ EID, MOTIVATIONS, NONPHARM
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

2023498981

REC 001821
AU Shiffman,S; Read,L; Maltese,J; Rapkin,D; Jarvik,ME
TTL Preventing Relapse in Ex-Smokers: A Self-Management Approach
CT Relapse Prevention, pp. 472-520
DT 1985
SUM Unrealistic expectations of the quitting process lead to unrealistic planning. Clients for whom quitting is difficult may need to make changes in work or social schedules to arrange for resources to deal with the added stress.; While skills training is the most prominent active ingredient in smoking cessation treatment, reorientation of clients' attitudes toward the quitting process is also important. It is helpful to provide the client with general guidelines and information about the quitting process. These guidelines are important in orienting the client toward (1) realistic expectations of quitting smoking, (2) recognition of the difference between initial quitting and maintenance stages, (3) the use of self-observation in maintenance, and (4) the use of coping strategies and responses in maintenance. We have said that clients often have inaccurate expectations of quitting and withdrawal processes. Frequently, their criteria for satisfactory progress are so unrealistically high that they become discouraged almost before they begin. Clients who by objective standards are quite successful in dealing with cravings may become upset because they fall short of their high expectations. Many clients expect a successful quitting effort to be free of struggle and are disappointed when they encounter difficulties, "I should be able to handle this without difficulty," or "it shouldn't be this hard for me. I must be doing something wrong," or "I guess I'm just not as strong as I thought," are common sentiments that reflect demoralizing and self-defeating attitudes. The fact that cravings are felt, that some situations are stressful, or that cigarettes are missed is interpreted as failure. In effect, these clients experience some aspects of the ave even before they have violated abstinence.; Actually, withdrawal symptoms usually subside after the first couple of weeks. Though the intensity of cravings may remain constant, their frequency usually diminishes as abstinence proceeds.
SUBJ IIA, WITHDRAWAL, NICOTINE
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

2024987982

REC 001822
AU Shiffman,S; Read,L; Maltese,J; Rapkin,D; Jarvik,ME
TTL Preventing Relapse in Ex-Smokers: A Self-Management Approach
CT Relapse Prevention, pp. 472-520
DT 1985
SUM Since smoking is often used to mask needs, smokers are often out of touch with important needs. This hampers selection of appropriate alternatives. Clients need help in labeling their needs and in finding other ways of satisfying them. In the section on coping skills, we discussed a number of substitutes that may be effective in reducing craving. Early in treatment, many substitutes may be used in lieu of having a cigarette. Many of these substitutes cannot be used for long periods of time without harmful side effects, however. Eating sweets or taking tranquilizers may be appropriate as stopgap measures, but create problems in long-term use. Such substitutes also perpetuate the cycle of deprivation, craving, and dependence. Clients need appropriate skills for satisfying the needs flagged by craving without smoking. A more satisfying, need-fulfilling lifestyle also makes craving for cigarettes less likely. The assumption here is that other behaviors can satisfy these needs at least as effectively as smoking and can therefore displace smoking as a valued activity.; Unrealistic expectations of the quitting process lead to unrealistic planning. Clients for whom quitting is difficult may need to make changes in work or social schedules to arrange for resources to deal with the added stress.; An important characteristic of the RP approach is its emphasis on self-management. This is a broad and ambitious conception of treatment. The RP approach does not promise or offer magical cures for smoking. It assumes that these are impossible because it sees the control of smoking as a problem of self-control. The RP model assumes that success in maintenance depends on the client, and aims to teach clients an approach to regulating their own behavior and their lifestyle. The client is not passively acted upon but is the active agent of treatment.; While skills training is the most prominent active ingredient in smoking cessation treatment, reorientation of clients' attitudes toward the quitting process is also important. It is helpful to provide the client with general guidelines and information about the quitting process. These guidelines are important in orienting the client toward (1) realistic expectations of quitting smoking, (2) recognition of the difference between initial quitting and maintenance stages, (3) the use of self-observation in maintenance, and (4) the use of coping strategies and responses in maintenance. We have said that clients often have inaccurate expectations of quitting and withdrawal processes. Frequently, their criteria for satisfactory progress are so unrealistically high that they become discouraged almost before they begin. Clients who by objective standards are quite successful in dealing with cravings may become upset because they fall short of their high expectations. Many clients expect a successful quitting effort to be free of struggle and are disappointed when they encounter difficulties, "I should be able to handle this without difficulty," or "it shouldn't be this hard for me. I must be doing something wrong," or "I guess I'm just not as strong as I thought," are common sentiments that reflect demoralizing and self-defeating attitudes. The fact that cravings

are felt, that some situations are stressful, or that cigarettes are missed is interpreted as failure. In effect, these clients experience some aspects of the ave even before they have violated abstinence.; While smoking may be a physical addiction to nicotine, we believe that the best approach to clinical treatment of smoking does not focus of this aspect of smoking behavior. We approach the modification of smoking behavior as a problem in self-control or self-management. The traditional emphasis on personal pathology or personal traits is replaced with a focus on critical situations and on personal self-management skills.; Data from diverse sources consistently indicate that the use of cognitive coping strategies is a critical element in successful maintenance.
SUBJ K1A, CESSATION, METHODS
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 001823
AU Shiffman,S; Read,L; Maltese,J; Rapkin,D; Jarvik,ME
TTL Preventing Relapse in Ex-Smokers: A Self-Management Approach
CT Relapse Prevention, pp. 472-520
DT 1985
SUM We wish only to add here that research has not supported the importance of personality traits in the maintenance of nonsmoking. Many attempts have been made to identify the traits associated with recidivism. With minor exceptions these attempts have failed (Smith, 1970). This ignores the fact that relapses are concrete events and that the first cigarette must be smoked at a specific time and place under particular circumstances. We believe that a focus on these "critical incidents" is more productive. Thus, the core of our approach is a focus on events and situations that trigger relapse. Clearly, however, no situation is sufficient to cause relapse. In order for a relapse to occur, the situational cues and the craving they engender must overwhelm the ex-smoker's capacity to cope or resist. Relapse occurs at the intersection of a triggering situation and a deficient coping response. Indeed, our work shows that the ex-smoker's coping response may be the critical factor in bringing about relapse. The development of skills for coping with relapse-facilitating situations is the major focus of our clinical approach.; The programmed relapse increased self-efficacy ratings and decreased reported craving. Follow-up data, however, revealed that the programmed relapse clients were somewhat more likely to relapse than were the absolute abstinence clients, though not significantly so. Moreover, the more a client's self-efficacy was enhanced by the procedure, the more likely he or she was to relapse. This suggests that the programmed relapse procedure may have observed that recidivists sometimes have higher self-efficacy than survivors just prior to a relapse crisis (Shiffman et al., 1981). Confidence without competence produces failure.; The greatest single cause of relapse is failure to attempt coping in relapse crises.
SUBJ K1DA, CESSATION, RELAPSE, NICOTINE
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 001824
AU Shiffman,S; Read,L; Maltese,J; Rapkin,D; Jarvik,ME
TTL Preventing Relapse in Ex-Smokers: A Self-Management Approach
CT Relapse Prevention, pp. 472-520
DT 1985
SUM The programmed relapse increased self-efficacy ratings and decreased reported craving. Follow-up data, however, revealed that the programmed relapse clients were somewhat more likely to relapse than were the absolute abstinence clients, though not significantly so. Moreover, the more a client's self-efficacy was enhanced by the procedure, the more likely he or she was to relapse. This suggests that the programmed relapse procedure may have observed that recidivists sometimes have higher self-efficacy than survivors just prior to a relapse crisis (Shiffman et al., 1981). Confidence without competence produces failure.
SUBJ K1F, CESSATION, SELF-EFFICACY
CD APRIL 2, 1987 JD/WC
UDT MAY 1, 1987 SHB

REC 003154
AU Shiffman,S; Read,L; Jarvik,M
TTL Smoking Relapse Situations: A Preliminary Typology
CT Int J Addict 20(2): 311-318
DT February, 1985
SUM
SUBJ
CD FEBRUARY 1, 1988 SHB

REC 002760
AU Shiffman,S
TTL A Cluster-analytic Classification of Smoking Relapse Episodes
CT Addict Behav 11: 295-307
DT 1986
SUM Few situational antecedents distinguished crises which resulted in smoking from those in which abstinence was maintained. Instead, exsmokers' coping responses - their attempts to resist temptation and forestall relapse - were the best predictors of the outcome of the crisis. Shiffman (1982a) concluded that situations in themselves do not cause relapse; situations bring about strong temptations to smoke, with the occurrence of relapse then determined by coping behaviors. (p. 296)
SUBJ K1DA, CESSATION, RELAPSE, NICOTINE
CD NOVEMBER 1, 1987 SHB

2023497985

REC 003097
AU Shiffman,S
TTL Overview: Integrating Pharmacological and Behavioral Approaches to Smoking Cessation
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 196-204
DT 1986
SUM . . . we are discovering that relatively few smokers want to be treated in clinics. It has been estimated that 95% of those who quit smoking do so without clinic treatment, and only 36% of smokers express a willingness to attend a smoking cessation clinic. (p. 198)
SUBJ K1AA, CESSATION, METHODS, NON-FORMAL
CD JANUARY 1, 1988 SHB

REC 003071
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Although studies of smoking initiation have focused on peer pressure as the key culprit, stress is also involved in smoking from its very beginnings. (p. 56)
SUBJ E1A, MOTIVATIONS, INITIATION
CD JANUARY 1, 1988 SHB

REC 003072
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM In adult smoking, stress reduction has long been considered a major motive for smoking. (p. 56)
SUBJ E1B, MOTIVATIONS, MAINTENANCE
CD JANUARY 1, 1988 SHB

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REC 003073
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Even in opiate addiction - the classical "physical" dependence - there's evidence that physiological factors alone are not enough to explain dependence. For example, it's clear that not everyone who repeatedly uses opiates becomes addicted. (p. 48)
SUBJ I1B, WITHDRAWAL, OTHER DRUGS
CD JANUARY 1, 1988 SHB

REC 003074
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Whatever one's motives for smoking, the relationship between stress and smoking is so strong that the amount of stress a smoker reports when quitting smoking is a good predictor of his or her success for as much as a year later. (p. 57); Quitting smoking requires more than nicotine - it requires motivation commitment, planning, effort, activity, and persistence. Nicotine and will-power are not enough. (p. 61)
SUBJ K1, CESSATION
CD JANUARY 1, 1988 SHB

REC 003075
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Negative affect was not only a common antecedent of relapse crises; typically, it was the factor that actually triggered the episode. (p. 57); Relapse to smoking is motivated by tension reduction more than by any other motive. As Dr. Pomerleau pointed out, nicotine is used to control tension and not just to reduce craving. (p. 59)
SUBJ K1DA, CESSATION, RELAPSE, NICOTINE
CD JANUARY 1, 1988 SHB

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REC 003076
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Besides motivation, there's another factor that's terribly important in enabling cessation, and that is self-efficacy (1). "Self-efficacy" is a fancy word for specific self-confidence, our belief in our own ability to accomplish a very specific goal, such as quitting smoking. (Psychologists make their living inventing new words for old concepts.) Carlo DiClemente and Jim Prochaska (4) and numerous other investigators have demonstrated how important self-efficacy is to smoking cessation. In their data, confidence in quitting distinguished those who succeeded in quitting from those who failed, those who tried to quit from those who did not, and those who gave up from those who remained interested in quitting. (p. 54)
SUBJ K1F, CESSATION, SELF-EFFICACY
CD JANUARY 1, 1988 SHB

REC 003077
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Although we don't generally focus on non-addicted smokers, it's clear that the same thing can be said of tobacco use - not all users are addicts (18). Only some are vulnerable to dependence, and the vulnerability depends on psychosocial factors, including the social context of the drug use. (pp. 48-49)
SUBJ N1A, NON-DEPENDENT USE, TOBACCO
CD JANUARY 1, 1988 SHB

REC 003078
AU Shiffman,S
TTL Psychosocial Factors in Smoking and Quitting: Health Beliefs, Self-efficacy, and Stress
CT The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress, November 4-5, 1985 (Smoking Behavior and Policy Conference Series) pp. 48-62
DT 1986
SUM Even in opiate addiction - the classical "physical" dependence - there's evidence that physiological factors alone are not enough to explain dependence. For example, it's clear that not everyone who repeatedly uses opiates becomes addicted. (p. 48)
SUBJ N1B, NON-DEPENDENT USE, OTHER DRUGS
CD JANUARY 1, 1988 SHB

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REC 002975
AU Shiffman,S
TIL Tobacco "Chippers": A Study of Non-Dependent Cigarette Smokers
CT Pharmacol Biochem Behav 25(1): 305
DT 1986
SUM . . . chippers showed no withdrawal and were unaffected by smoking.
SUBJ F1A, PHYSIOLOGICAL EFFECTS, NICOTINE
CD JANUARY 1, 1988 SHB

REC 002976
AU Shiffman,S
TTL Tobacco "Chippers": A Study of Non-Dependent Cigarette Smokers
CT Pharmacol Biochem Behav 25(1): 305
DT 1986
SUM . . . chippers showed no withdrawal and were unaffected by smoking.
SUBJ G1A, PSYCHOLOGICAL EFFECTS, NICOTINE
CD JANUARY 1, 1988 SHB

REC 002977
AU Shiffman,S
TTL Tobacco "Chippers": A Study of Non-Dependent Cigarette Smokers
CT Pharmacol Biochem Behav 25(1): 305
DT 1986
SUM . . . chippers showed no withdrawal and were unaffected by smoking.
SUBJ I1A, WITHDRAWAL, NICOTINE
CD JANUARY 1, 1988 SHB

REC 000910
AU Shiffman,S; Hughes,JR; West,R; Marlatt,GA; Stockwell,T
TTL Comments on Kozlowski & Willinson's Use and Misuse of the Concept of Craving by Alcohol, Tobacco, and Drug Researchers'
CT Br J Addict Vol. 82, p. 37-46
DT 1987
SUM Craving now shoulders so many connotations that it may no longer be able to be used objectively. (p. 38); . . . there is no agreement on whether craving is a physiological, subjective or behavioral state or what are the physiological, subjective and behavioral referents for the construct. (p. 38); . . . I believe that, at present, the variety of meanings for the construct of craving precludes its utility. (p. 38); Craving lies at the heart of addiction. Yet, as Kozlowski & Wilkinson's paper illustrates, it has not proved possible to agree upon a definition of this important concept. (p. 39); There are problems with equating craving with the dysphoria of withdrawal. Not all craving experiences are associated with physical withdrawal. The pregnant mother who craves dill pickles and ice cream is not suffering from withdrawal. (p. 42)
SUBJ A1G, TERMS, CRAVING
CD APRIL 1, 1987 SHB
CHAR F

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